2. Interest expense on borrowed funds which are not used for operating the nursing home shall not be allowable.

3. An amount will be disallowed from working capital interest expense by applying an 8.3% per annum interest factor to the following amounts from the base cost reporting period. This standard disallowance shall only be applied to interest expense which exceeds $.10 per adjusted patient day (after applying 1 and 2 above).

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and owners equity distributions during the base cost reporting period;

4. This adjustment (4) will only be applied to any interest expense which exceeds $.20 per adjusted patient day after applying adjustment 3 above. An amount will be disallowed from interest expense by applying 8.3% to the following amounts from the cost reporting periods which were used in calculating the June 30th payment rate for the three years prior to the current payment rate year.

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and equity distributions during the cost reporting periods.

5. Interest on debts to acquire plant assets, which is not reimbursed under the property allowance in Section 3.500, shall not be allowed as interest in the administrative component.

1.281 Therapy and Beauty and Barber Shop Spaces

Support service, fuel and utility, property tax, and property expenses which are indirectly allocated to therapy services and beauty and barber services, on the basis of the building area which those services use, shall be generally allowed in the calculation of the payment rate. If gross therapy revenues (physical, occupational, and speech) are less than $100,000 for the applicable cost reporting period, then space allocations will not be made. If gross therapy revenues (physical therapy, occupational therapy, and speech therapy) generated in nursing home therapy space attributable to non-nursing home residents equal 2% or more of total gross therapy revenues and/or if the nursing facility (or a related party as defined in Section 1.252) bills Medicare Part B for therapy generated in the nursing facility therapy space and the Medicare Part B revenues equal 10% or more of the total therapy revenues, then space allocations shall be made on a square footage basis. If the nursing home is subject to an allocation under the Medicare Part B criterion, then the non-nursing home resident allocation will be made if there are any non-nursing home resident therapy revenues. These qualifying criteria are based on the facility's cost reporting period for the payment rates.

1.282 Transportation

Revenues from transportation services shall be offset against transportation or administrative cost center expenses. In lieu of a revenue offset, expenses appropriately allocated by the nursing home to the revenue-generating transportation services may be offset against the cost center expenses.

1.290 Institutions for Mental Disease and Mentally Ill Nursing Home Residents

Sections 1.291 through 1.294 describe limitations on payments to institutions for mental disease and nursing homes for the care of mentally ill residents, as required by 1987 Act 399.

1.291 Limitation on Payment

Operating, capital and ancillary costs attributable to the care of 21 through 64 year old residents of an institution for mental disease are not allowable costs, except that costs for 21 year old residents are allowable if the resident resided in the institution for mental disease immediately prior to turning 21.

1.292 Limitation on IMD Patient Days

This section applies to IMDs and facilities declared to be at risk of being IMDs which agree to receive a permanent limitation on payments, pursuant to s. 46.266(1)(am), Wis. Stats. For these facilities, costs attributable to Medicaid patient days in excess of the patient day cap are not allowable costs. The patient day cap is determined as follows:

Patient day cap = 365*[A + (B-C)], where

A = The number of Medicaid eligible residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

B = The total licensed beds in the facility on the date that the facility agrees to receive the permanent limitation on payments.

C = The total residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

The patient day cap may be increased by 365 patient days for each resident who was not eligible for Medicaid on the date the facility was declared an IMD or at risk of being an IMD, but who becomes eligible at a later date.

1.294 Cap on Mentally Ill Nursing Home Residents
Pursuant to s.49.45(6j), Wis. Stats., the number of mentally ill Medicaid recipients in a nursing home determined by the Department to be at risk of being an IMD may not exceed the average population of mentally ill Medicaid recipients age 21 through 64 (excluding persons under 22 who were receiving Medicaid services in the facility prior to July 1, 1988, and continuously thereafter) in the nursing home during the period from January 1, 1987, through June 30, 1988. Costs attributable to mentally ill residents of the facility in excess of the average population are not allowable costs.

1.296 Hospice
If an NF contracts with a hospice to provide care for a terminally ill resident, costs attributable to care for that resident are not allowable costs.

For cost allocation purposes, hospice patient days shall be treated as any Medicaid patient days for allocating all but direct care costs. To allocate direct care costs:

a. A residential level of care shall be assigned to hospice patient days for persons who are permanent residents of the facility; and

b. A medical level of care as appropriate shall be assigned to hospice patient days for persons admitted for temporary stays.

1.300 GENERAL DEFINITIONS

1.301 Active Treatment
Active treatment for developmentally disabled and mentally ill nursing home residents means an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

1.302 Base Cost Reporting Period
Payment rates shall be based upon information from cost reports for the provider's fiscal year ending in the calendar year prior to effective date of the payment rates per Section 1.132, except that the property tax allowance shall be based on the cost reporting periods described under Section 3.400. Payment rates may be based on alternative cost reporting periods acceptable to the Department, whenever allowed under the provisions of Section 4.000 of this Methods.

Expenses included in a reporting period are to be on the accrual basis of accounting, except where otherwise noted. For reimbursement purposes, the accrued expense must be paid within 180 days following the end of the reporting period. An expense disallowed under this section in any cost report period may not be claimed on a subsequent cost report. Specific exceptions to the 180 day rule may be granted by the Department for documented contractual arrangements such as receivership, property tax installment payments, and pension contributions; or expenses relating to audit of another provider group if the audit settlement indicates acceptance of these costs in writing. Note Section 1.248 for pending claims for self-insurance costs.

For 2000-2001 rates, the facilities' 1999 cost reports will be used to calculate payment rates. Exceptions to this may be for facilities in a start-up or phase-down period per Sections 4.300, 4.400, 4.500 and 4.600 as mentioned in Section 1.302.

1.303 Common Period
The common period to which expenses will be inflated or deflated is the twelve-month period preceding the payment rate year described in Section 1.314. For 2000-2001 payment rates, the common period covers the twelve months of July 1999 through June 2000.

1.304 Definition of Significant Changes in Licensed Bed Capacity
Unless otherwise stated in this Methods, a significant increase or decrease in licensed bed capacity is defined as the lesser of: (1) a change that is greater than or equal to 25.0% of the previously unrestricted use licensed beds or (2) 50 beds.

1.305 New Facilities
A new facility is defined as a nursing home newly beginning operation and not previously licensed as a nursing home. A change in ownership does not constitute a new facility. An existing operation, which becomes certified for the Medicaid Program, shall not be considered a new facility.

1.306 Replacement Beds and Facilities
A replacement is defined as the licensure and certification by a Medicaid provider of beds to take the place of beds closed or de-licensed by the same or a related provider. Total replacement means all beds under a provider's certification were replaced. The resulting licensed bed capacity of the provider may be considered a significant increase or decrease in licensed beds if the criteria of Section 1.304 are met.

1.307 Adjusted Patient Days
The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% discount on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

1.308 Fringe Benefits
The term "fringe benefits" refers to general fringe benefits for staff as defined in detail by the Department in the Medicaid nursing home cost report form. Significant, unique benefits, as defined in the cost report form, are to be included as a salary or wage expense under this Methods and not as a fringe benefit expense. For facilities with special salary and wage payments to employees, such as bonuses, the Department shall classify such payments as salaries instead of fringe benefits.

1.309 Average Licensed Beds
The term "average licensed beds" means the average of the number of licensed beds of the facility on the last day of each month of the period for which the average is being determined. An average for a one-month period shall be the average of the daily number of licensed beds.

1.310 Significant Licensed Bed Days
A significant number of licensed bed days is the lesser of 4500 licensed bed days or 25.0% of the annualized bed days of the provider.

1.311 Distinct Part ICF-MR
A distinct part ICF-MR is a specific segment of a licensed NF facility which has been certified by the Department as a distinct part intermediate care facility for the mentally retarded.

1.312 Institution for Mental Disease (IMD)
An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or the federal Health Care Financing Administration. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

1.313 Restricted Use Beds
Restricted use beds are those beds that have been acquired by sale or transfer from a separate licensee and which cannot be occupied by patients pending Chapter 150 approval of construction of a facility that can accommodate the beds. Restricted use beds are not to be used for determining bed hold occupancy requirements. Restricted use beds with a restricted use license issued prior to July 1, 1995, will not be included in the average licensed beds under Section 1.309. Restricted use beds with a restricted use license issued after June 30, 1995, will be included in the average licensed beds under Section 1.309.

1.314 Payment Rate Year
The payment rate year is the twelve month period from July 1, 2000 through June 30, 2001.

1.315 Patient Day
A patient day is one in which a patient, regardless of pay source, resides in a nursing facility for any part of a calendar day. This includes the day of admission but not the day of discharge. If the day of admission and discharge are the same it will be considered one patient day. Bed hold days reimbursed by the fiscal intermediary or patient are considered a patient day (Medicaid bed hold days must meet the billable criteria identified in Section 1.500.) A patient day can not be counted as both a patient day and a bed hold day.

1.316 Beds for Rate Setting
The beds for rate setting will be calculated as described in Section 3.040.

1.400 NURSING HOME APPEALS BOARD

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute. With the assistance of the Department, the Appeals Board shall develop written policies to ensure that the criteria required by statute are taken into account.

1.500 BED HOLD DAYS

Hospital bed hold days and therapeutic bed hold leave days will be paid at 85.0% of the full rate for qualifying facilities. A maximum of 15 consecutive days is payable for each hospitalization leave. In order to qualify to bill for bed hold, facilities must meet occupancy criteria below. (Reference: HFS 107.09(3)(j), Wis. Adm. Code).

1.510 Bed Hold Occupancy Requirements

Hospital and/or therapeutic bed hold leave can be billed to the Medicaid Program if the certified provider's occupancy level is an average of 8.0 or fewer vacant licensed beds, or a 95.0% or greater occupancy rate during the calendar month prior to the bed hold leave days. If either test is met, then the subsequent month's bed hold days may be billed. Minimum occupancy requirements for bed hold billing apply to new or expanded facilities. Homes in start-up must meet bed hold occupancy provisions.

Any facility pursuing a phase-down of resident population due to a licensed bed reduction or a phase-out may be exempted from the above occupancy requirements. The phase-down or phase-out and its expected time period must be approved in writing and in advance by the Department before such exemption shall be allowed.

1.520 Calculation of Occupancy for Bed Hold Billing

The occupancy in the month prior to the bed hold leave days shall be the basis for determining if the bed hold days in the subsequent month can be billed. Average vacant beds (for the "8.0 or fewer" test) shall be determined by subtracting the month's average midnight census days from the sum of the average licensed beds less any restricted use beds of each certified provider for the month. The occupancy rate (for the "95.0% or greater occupancy rate" test) shall be determined by dividing the total patient days by the number of licensed bed-days for the month. For this calculation only, licensed bed-days shall not include any restricted use beds. Charged bed hold days for any resident shall be included as one full patient day.

1.521 Combined Occupancy Test for Multiple Providers

A provider, at its option, may combine the occupancy calculation under Section 1.520 for two or more separately certified facilities if the facilities are located on the same or contiguous property and are fully owned by the same corporation, governmental unit or group of individuals. The election to combine or separate facilities for the occupancy can differ from one month to the next month. Distinct part facilities may also utilize this occupancy test.

1.530 Excludable Licensed Beds See page 11.a.

Licensed beds may be reduced for (a) isolation beds, (b) seclusion beds, (c) certain code violations, and (d) renovations in order to calculate the occupancy for bed hold billings. Excluded beds must meet one of the following criteria:

1. Isolation beds must be in rooms qualifying under HFS 132.84(12), Wis. Adm. Code, and used only for the temporary isolation of residents. Excluded licensed beds may not exceed one bed for every 100 beds or fraction thereof, unless more beds are specifically approved by the Department.

2. Seclusion beds (1) must be in a lockable room, the door to which required a licensure waiver, (2) must be used for seclusion only and always be available for seclusion, and (3) must be only used temporarily for calming disruptive residents. Only one licensed bed per seclusion room may be excluded.

3. For code violations, excluded beds must be out-of-use due to life safety code violations cited by the Department. The Department must be notified of such beds.

4. For renovation, licensed beds must be out-of-use due to renovation projects. The excluded beds and the expected time period of the exclusion must be prior approved by the Department.

5. Beds banked under Section 3.060.

6. Restricted Use Beds

1.540 Documentation

Sufficient documentation by a certified provider assuring the Department that requirements permitting billing for bed hold days have been met must be provided upon request. If a certified provider does not supply sufficient documentation, payments for unsupported billings may be recouped by the Department.

1.530 Excludable Licensed Beds

Licensed beds may be reduced for (a) isolation beds, (b) seclusion beds, (c) certain code violations, and (d) renovations in order to calculate the occupancy for bed hold billings. Excluded beds must meet one of the following criteria:

1. Isolation beds must be in rooms qualifying under HFS 132.84(12), Wis. Adm. Code, and used only for the temporary isolation of residents. Excluded licensed beds may not exceed one bed for every 100 beds or fraction thereof, unless more beds are specifically approved by the Department.

2. Seclusion beds (1) must be in a lockable room, the door to which required a licensure waiver, (2) must be used for seclusion only and always be available for seclusion, and (3) must be only used temporarily for calming disruptive residents. Only one licensed bed per seclusion room may be excluded.

3. For code violations, excluded beds must be out-of-use due to life safety code violations cited by the Department. The Department must be notified of such beds.

4. For renovation, licensed beds must be out-of-use due to renovation projects. The excluded beds and the expected time period of the exclusion must be prior approved by the Department.

5. Beds banked under Section 3.060.

6. Restricted Use Beds. Restricted use beds are beds that exceed a nursing home's normal maximum bed capacity or are not in use due to remodeling. If a facility is remodeling a portion of the nursing home, and the beds will not be available until after the remodeling is complete, the beds are shown as restricted use beds. Beds may also be restricted use beds if they are transferred to a nursing home because of one of the following three circumstances: 1) bankruptcy, 2) a physical plant with less than 50 beds that needs replacement, or 3) a physical plant with life safety code problems. This applies if space is currently not available for these beds.

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1.550 No Charge to Resident and Third Party

NO RESIDENT OR THIRD PARTY MAY BE CHARGED FOR COVERED BUT UNREIMBURSED BED HOLD OR THERAPEUTIC BED HOLD LEAVE DAYS OR SERVICES OF A MEDICAID RECIPIENT. Beds held for the following leaves are deemed to be Medicaid-covered services, even when a certified provider does not meet the above occupancy requirements:

-- All hospital leaves of absence up through 15 days per hospitalization
-- All leaves for therapeutic visits
-- All leaves for therapeutic rehabilitative programs meeting the criteria under HFS 107.09(3)(j), Wis. Adm. Code.

1.600 RESOURCE ALLOCATION PROGRAM RATES AS A MAXIMUM

The per patient day property allowance stated in an application to the state's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable payment that may be granted by the Department for applications not involving the addition of beds for the first full year following completion of the project. In an application for approval of additional beds, the per patient day rate(s) stated in an application to the State's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable reimbursement that may be granted by the Department for the twelve months following licensure of the additional beds. If the Methods generates per patient day rates or per patient day property allowance that are less than those stated in the application, the Department shall use the lower rate(s) or allowance.

This section does not apply to ICF-MR facilities certified after June 30, 1988.

Resource Allocation Program maximums shall be applied for the first full year following completion of a project or the time period specified in the RAP approval.

1.700 CHAPTER 227 ADMINISTRATIVE HEARINGS

A facility may contest a final rate-setting action of the Department by writing to the Department of Administration's Division of Hearings and Appeals at P.O. Box 7875, Madison, WI 53707-7875. The rate approval letter issued to the facility by the Department is the formal written Notice of Action required by the state administrative code (Reference: HFS 106.12, Wis. Adm. Code). The request for hearing must be served within 15 days of receipt of a Notice of Action. It must contain a brief and plain statement identifying every matter or issue contested.

1.800 ADMINISTRATIVE REVIEWS

A facility may request an administrative review of the Department's cost finding decisions prior to the issuance of a rate approval letter. The request must be filed within 30 days of the facility's receipt of the notification of Medicaid nursing home rates and shall be subject to any other procedures or criteria developed by the Department. A facility's failure to file a timely request for an administrative review shall have no bearing on the facility's right to file a request for administrative hearing under Section 1.700 or an appeal to the Nursing Home Appeals Board under Section 1.400 upon issuance of the rate approval letter. All administrative reviews should be sent to:

David Lund, Nursing Home Section Chief
Division of Health Care Financing
P.O. Box 309
1 West Wilson
Madison, WI 53701-0309

1.900 MEDICARE BILLING

Facilities must bill Medicare for covered services and supplies. Facilities that bill Medicare for applicable Part B services must be dually-certified facilities, and must bill Medicare for Medicare-covered services or supplies prior to billing Medicaid. Providers are expected to bill the Medicare Part B program for any services or supplies for residents covered by that program. Should a provider not exhaust Medicare Part B sources of revenue, then the Department may offset that amount or an estimate of that amount which could be billed to Medicare Part B. This policy applies to facilities which do not bill Medicare at all or do not exhaust Medicare to the extent available for applicable Medicare third-party liability.

SECTION 2.000 PAYMENT RATE ALLOWANCES DESCRIBED

This Methods provides for payments which are divided into seven major cost centers: Direct Care; Support Services; Administrative and General; Fuel and Utilities; Property Tax; Property and Over-the-Counter Drugs. Section 2.000 describes the types of services and costs generally covered by each cost center. The calculation of the payment allowances is described in Section 3.000.

2.100 DIRECT CARE ALLOWANCE

The direct care allowance shall reimburse for allowable facility expenses related to the provision of the following purchased and/or provided services and supplies, (which include, but are not limited to, staff wages, fringe benefits, and purchased services costs) up to maximums discussed in Section 3.100.

2.110 Professional Nursing Services

Professional nursing services shall include all registered nurses, nurse practitioners and licensed practical nurses.

2.120 Supporting Care Services

Supporting care services shall include technical, non-professional resident living staff, volunteer coordinators, nurses aides and ward clerks, activity and recreation staff, and therapy aides and assistants.

2.130 Professional (Non-Medical/Clinical Care) Services

Professional care services shall include: teachers and vocational counselors for residents aged 22 and over, social services, educational and vocational expenses that are part of an active treatment plan in facilities licensed as ICF-MRs, chaplain and religious services, and the non-billable services of pharmacy, x-ray, laboratory, dentists, physicians, physician assistants, licensed registered therapists, chiropractors, psychiatrists, and psychologists. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per HFS 107, Wis. Adm. Code.

The cost of non-covered services identified in HFS 107, Wis. Adm. Code or Department policies shall not be reimbursed.

Expenses for the time to perform overhead activities related to billable therapy evaluations, procedures and modalities are not to be included in the rate calculation and are not to be considered in the cost report category of "non-billable expenses." Activities such as end-of-the-day clean-up time, transportation time, consultation and required paper reports are considered to be overhead activities.

Any nursing personnel, quality assurance personnel and/or therapy consultants who do not provide direct, hands on patient care shall be considered administrative and general expenses.

2.135 Inservice Training

The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to nurse aide training and competency evaluation programs (NAT/CEP) mandated by OBRA shall not be included in the daily rate; separate reimbursement is provided for the direct expenses incurred by a nursing facility for NAT/CEP that is required before an aide can be entered on the Nurse Aide Registry.

2.140 Personal Comfort, Medical Supplies

Personal comfort, medical supplies and other similar supplies, along with special care supplies are included in the direct care allowance. Section 5.100 of this Methods contains further guidelines on, and a list of, the personal comfort and medicine chest-type supplies which are intended to be included under this provision.

2.150 Incontinent Supplies

Incontinent supplies shall include the cost of underpads, blue pads, disposable diapers, reusable diapers, the purchased service costs of a diaper/underpad service, catheter sets and supplies, and bladder irrigation sets and supplies. Section 5.100 of this Methods contains further guidelines on, and a list of, the incontinent-type supplies which are intended to be included under this provision.

2.200 SUPPORT SERVICES ALLOWANCES

The support services allowance recognizes the allowable expenses to provide dietary and environmental services up to amounts payable under Section 3.200. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.210 Dietary Service Expenses

Dietary service expenses are those expenses directly related to the provision of meals to residents of the facility, including dietary supplements and dietician consultants.

2.220 Environmental Service Expenses

Environmental service expenses are generally those expenses related to the provision of maintenance, housekeeping, laundry and security services. Also included are expenses related to residents' personal laundry services, excluding personal dry cleaning services. Residents are NOT to be charged for the laundering of gowns.

2.250 ADMINISTRATIVE AND GENERAL SERVICES ALLOWANCE

The administrative and general service allowance recognizes the allowable expenses for administrative, central office services and management services contract fees up to amounts payable under Section 3.250. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.251 Administrative Service Expenses

Administrative service expenses include those expenses related to the operation's overall management and administration, and other allowable expenses which cannot be appropriately recognized/reimbursed in other payment allowances or service areas. Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses. A nursing home may also include the allowable ownership and/or rental expenses of telephone equipment, and computer and electronic data processing equipment. (Inservice training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)

2.252 Central Office Costs

Administrative expenses allocated to the nursing home from centralized administrative units of nursing home chain organization or governmental agencies shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

A facility that claims both central office expense and in-house administrative and general expense will be subject to the following standards for reasonable and necessary salary and fringe benefit expense in this cost center:

If total in-house salary and fringe benefits are greater than or equal to the Central Office Cost allowance which is $6.36 per patient day, no central service salary or fringe benefits is reimburseable.

If total in-house salary and fringe benefits is less than the per patient day Central Office Cost allowance, then central service salary and fringe benefit expense is reimbursed to bring the total in-house and central service salary and fringe benefits to a maximum per patient day Central Office Cost allowance of $6.36.

2.253 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted by the Department for unreasonable or unnecessary levels of service, compensation, or duplicative services. Fees resulting from a percentage of cost or revenue arrangement will be disallowed by the Department, in whole or in part, according to the policy established by the Department. If actual management costs can be documented, those costs (subject to Medicaid allowability) may be substituted for the amount reported up to the amount actually paid.

2.254 Nursing Home Valuations

The cost of Department-required nursing home property valuations conducted by a Department-approved contractor shall be recognized among administrative service expenses.

2.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

The fuel and other utility expense allowance shall consist of allowable facility expenses related to the provision of electricity, water and sewer services, and heating fuel including fuel oil, natural gas, LP gas, coal and other heating fuels.

2.400 PROPERTY TAX ALLOWANCE

2.410 Tax-Paying Facilities

The property tax allowance shall be a per patient per day amount for allowable property tax expense. Allowable property tax expense shall exclude any state property tax credit and any special assessments for capital improvements, such as sewers, water mains and pavements. Whenever exemptions to property tax are legally available, the provider shall be expected to pursue such exemptions. If the provider does not pursue available exemptions, the expenses incurred for property tax shall not be allowed.

2.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt facilities may include a per patient per day amount for the cost of needed municipal services. Includable municipal services will be limited to those services which are financed through the municipality's property tax and which are provided by the municipality to property taxpayers without levying a special fee for the service. A tax-exempt facility may be paying a municipal service fee to the municipality for the services or may provide the service and incur the cost in their own operation.

2.500 PROPERTY PAYMENT ALLOWANCE

The property payment allowance will be a per patient day amount based upon the value of a facility's buildings as estimated by a commercial estimator, target amounts based on service factors established by the Department, and the nursing home's allowable property-related expenses. The estimation will conform with guidelines determined by the Department. This allowance covers, in whole or in part, the nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

2.600 OVER-THE-COUNTER DRUG ALLOWANCE

The Department will reimburse for nonprescription charges approved by the Department through an over-the-counter drug allowance which recognizes the allowable expenses to provide certain over-the-counter drugs, ordered by a physician, to Wisconsin Medicaid nursing home residents up to amounts payable under Section 3.600. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

2.700 PROVIDER INCENTIVES

2.710 Exceptional Medicaid/Medicare Utilization Incentive

Nursing homes, other than those owned and operated by a governmental entity, with exceptional Medicaid/Medicare utilization, described in Section 3.651, may receive the payment incentive. The payment incentive is the F percentage in Section 3.651 times the base rate in Section 5.920. Ownership status is determined as of the last day of the cost report. If a governmental facility changes ownership status, it will not be eligible for this incentive until such time that the change in ownership status has been reflected on the cost report used to set the rate for the applicable rate year.

2.720 Private Room Incentive

Nursing homes may be eligible to receive a Basic Private Room Incentive (PRI), a Renovation Private Room Incentive (RPRI) or a Replacement Private Room Incentive (RPPRI). To determine eligibility, nursing homes must meet licensed bed and patient day requirements. To receive either incentive, nursing homes must submit an affidavit to the Department during the reimbursement year stating that they will not charge Medicaid residents the surcharge for private rooms allowed under HFS 105.09(4)(k) as of the date the incentive would be effective.

1. Basic Private Room Incentive. Effective July 1, 2000. Nursing homes which meet both the exceptional Medicaid/Medicare utilization, see Section 2.710, and have an extraordinary number of single occupancy rooms equal to the private room percentage (PRP) listed in Section 3.653(a), may receive a payment incentive. This Basic Private Room Incentive is based on the percentage of rooms licensed for single occupancy to total licensed beds. Licensed bed and patient room requirements are listed in Section 3.653(a).

2.720 Private Room Incentive

Nursing homes may be eligible to receive a Basic Private Room Incentive (PRI), a Renovation Private Room Incentive (RPRI) or a Replacement Private Room Incentive (RPPRI). To determine eligibility, nursing homes must meet licensed bed and patient day requirements. To receive either incentive, nursing homes must submit an affidavit to the department during the reimbursement year stating that they will not charge Medicaid residents the surcharge for private rooms allowed under HFS 105.09(4)(k) as of the date the incentive would be effective.

1. Basic Private Room Incentive. Effective 7/1/2000. Nursing homes which meet the both exceptional Medicaid/Medicare utilization, see Plan section 2.710, and have an extraordinary number of single occupancy rooms equal to the private room percentage (PRP) listed in Plan section 3.653(a), may receive a payment incentive. This Basic Private Room Incentive is based on the percentage of rooms licensed for single occupancy to total licensed beds. Licensed bed and patient room requirements are listed in Plan section 3.653(a).

2. The Renovation Private Room Incentive (RPRI) is for facilities that undergo substantial renovation for the sole purpose of converting existing space into single rooms subsequent to 7/1/2000. For purposes of this section, substantial means the cost of the renovation project must be at least 25% of the total URC, as defined in Plan section 3.531 (b). The RPRI for renovated facilities will be effective the first day of the month following completion of the renovation or 7/1/2001 whichever is later. The facility must meet the exceptional Medicaid/Medicare utilization in Plan section 2.710 and the private room percentage (PRP) listed in Plan section 3.653(b) after the renovation is complete.

3. The Replacement Private Room Incentive (RPPRI) is for facilities replacing 100% of the patient rooms and will be effective the first day of service in the replacement facility or 7/1/2001 whichever is later. The replacement facility must meet the exceptional Medicaid/Medicare utilization in Plan section 2.710 and the private room percentage (PRP) listed in Plan section 3.653(b). If a facility does not replace 100% of the patient rooms they may still qualify for the RPRI or BPRI.

Effective 07-01-00

2. The Renovation Private Room Incentive (RPRI) is for facilities that undergo substantial renovation for the sole purpose of converting existing space into single rooms subsequent to July 1, 2000. For purposes of this section, substantial means the cost of the renovation project must be at least 25 percent of the total URC, as defined in Section 3.531 (b). The RPRI for renovated facilities will be effective the first day of the month following completion of the renovation or July 1, 2001, whichever is later. The facility must meet the exceptional Medicaid/Medicare utilization in Section 2.710 and the private room percentage (PRP) listed in Section 3.653(b) after the renovation is complete.

3. The Replacement Private Room Incentive (RPPRI) is for facilities replacing 100 percent of the patient rooms and will be effective the first day of service in the replacement facility or July 1, 2001, whichever is later. The replacement facility must meet the exceptional Medicaid/Medicare utilization in Section 2.710 and the private room percentage (PRP) listed in Section 3.653(b). If a facility does not replace 100 percent of the patient rooms they may still qualify for the RPRI or BPRI.

2.730 Energy Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility may receive an incentive per the calculation method in Section 3.652. In order to qualify for this incentive, the project must have been approved in advance by the Department. During the approval process the Department will consider:

a. The projected savings from the project based on an independent analysis to be provided by the facility. Such analysis may be provided by a public utility or an independent contractor qualified in engineering, architecture, or energy audits.

b. The projected cost of the project.

c. The combined simple payback for all projects proposed for the facility must be less than ten years.

Allowable costs for the incentive will be the lower of: 1) the amount approved in advance by the Department, or 2) the cost of equipment, installation, engineering, energy management and consultant fees prior to rebates. Interest, bond discounts, premiums and financial and/or auditing fees will not be an allowable cost for the incentive.

Replacement boilers that are not part of a co-generation project, replacement central air conditioners, condensers and windows, if included in a project approved or started after July 1, 2000, are excluded from this incentives, although fuel conversion projects are valid projects for this incentive.

SECTION 3.000 CALCULATION OF PAYMENT ALLOWANCES

3.001 Introduction
The payment allowance calculations are described in this section. For the payment system, the calculations of the allowances are on a per patient day basis. The patient days may be adjusted for minimum occupancy.

3.010 The Minimum Occupancy Standard

The minimum occupancy standard is 90.5%.

3.020 Adjusted Patient Day
The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% reduction on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

3.030 Minimum Occupancy Factor
The nursing home occupancy is determined by the adjusted patient days in Section 3.020 divided by the available bed days (beds for rate setting in Section 3.040 multiplied by the days in the cost reporting period). If the nursing home occupancy is less than the occupancy standard in section 3.010, the minimum occupancy factor is the ratio of the actual nursing home occupancy to the minimum occupancy standard. If the nursing home occupancy is equal to or greater than the occupancy standard, the minimum occupancy factor is 1.0.

3.040 Beds for Rate Setting
The beds for rate setting will be calculated as follows:

- Licensed beds on the last day of the 1999 cost report;
- Less the beds in the bed bank on the last day of the 1999 cost report;
- Less any additional beds deposited after the close of the 1999 cost report but before July 1, 2000.

3.050 Adjustments

1. If a free-standing ICF-MR facility has decreased its use of unrestricted licensed beds by the lesser of 10 beds or 10%, the facility may request that the reduced number of beds to be used in calculating the patient days at minimum occupancy (Section 3.030). Any resulting rate change is to be effective the first of the month following the decrease in licensed beds.
2. Restricted use beds with a restricted use license issued before July 1, 1995 will be excluded from the beds for rate setting.
3. Beds that are part of RAP projects, as defined in Section 1.240, will be excluded from Beds for Rate Setting if the project(s) is completed by July 1, 2000.
4. Facilities that have qualified for a Section 4.800 adjustment relating to beds out-of-use for renovation projects shall also qualify for a reduction to beds for rate setting. The reduction shall be equal to the monthly weighted average of the beds out-of-use during the cost report period used for rate setting.

3.060 Bed Bank
The Department shall exclude banked nursing home beds from the beds for rate setting (Section 3.040).

For bed bank requests submitted after June 30, 2000, the bed adjustment will be effective July 1, 2001, subject to the Methods then in effect.

If a bed license is split after the end of the cost report period, causing a transfer of beds between more than one facility and there are banked beds on the license, a new rate will be calculated for each facility, effective July 1, 2001, subject to the Methods then in effect, unless Sections 4.400 or 4.500 apply.